

Case Number:	CM14-0192588		
Date Assigned:	11/26/2014	Date of Injury:	04/01/2013
Decision Date:	01/13/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	11/18/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 21 year old male sustained a work related injury on 04/01/2013. According to progress notes dated 09/15/2014, the injury occurred when the injured worker was picking up a 50 pound box of meat when he twisted his body towards the left and felt a pop in his low back. Subsequently he felt immediate pain in his back. Pain began radiating into his right lower extremity to his knee with associated tingling and numbness. Chiropractic treatments and medications received were noted as not beneficial. According to the provider, an MRI of the lumbar spine was performed on 05/21/2013. The report was not submitted for review. The injured worker received an epidural steroid injection on 08/21/2013 without benefit. On February 19, 2014, an MRI of the lumbar spine revealed showed multilevel disc dessication with herniation and stenosis. This report was not submitted for review. An ultrasound on 04/08/2014 of the lumbar spine was consistent with chronic inflammatory process. The injured worker complained of constant pain in the low back that was aggravated by bending, lifting, twisting, pushing, pulling, prolonged sitting, prolonged standing and walking multiple blocks. Pain was characterized as stabbing. There was radiation of pain into the right lower extremity to the knee with associated tingling and numbness. There were associated headaches noted. According to the provider, the injured worker's pain was worsening. Pain was rated 8 on a scale of 1-10. Physical examination of the lumbar spine revealed pain and tenderness right across the iliac crest into the lumbosacral spine, most pronounced on the right side extending down the right lower extremity. Seated nerve root test was positive. This appeared to be in the L5 root. Standing flexion and extension were guarded and restricted. There was no clinical evidence of instability on exam. Circulation in the lower extremities was full. Coordination and balance were intact. There was tingling and numbness in the lateral thigh, anterolateral leg and foot and L5 dermatomal pattern. There was full strength in the EHL, an L5 innervated muscle. Diagnosis

included lumbar discopathy. Plan of care included a comprehensive exercise program, weight loss and possible surgical intervention could not be ruled out. The injured worker was to return to full duty without limitations on a trial basis. According to a progress note dated 10/22/2014, pain was unchanged. Diagnoses included lumbar disc displacement and lumbago. Work restrictions were checked as modified and temporarily totally disabled if modified duty was not available. A request was made for electrodiagnostic studies of the bilateral lower extremities. According to the provider, MTUS guidelines noted that Electromyography including H-reflex tests may be useful to identify subtle focal neurologic dysfunction in patients with lower back symptoms lasting more than 3-4 weeks. The provider also noted the Official Disability Guidelines that stated Electromyography (EMG)/Nerve Conduction (NCV) Velocity studies are recommended and generally accepted as well established and widely used for focal nerve entrapment such as radiculopathy. On 11/04/2014 Utilization Review non-certified the request that was received on 10/29/2014 for EMG of the right and left lower extremity and NCV of the right and left lower extremity. According to the Utilization Review physician the injured worker was not presented as having a specific deficit of radiculopathy. There was no presenting evidence of peripheral neuropathic change and there was insufficient information provided by the attending health care provider to associate or establish the medical necessity or rationale for the requested electrodiagnostic studies.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

EMG of the right lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Complaints Section

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Table 12-8 309.

Decision rationale: This 21 year old male sustained a work related injury on 4/1/13 from picking up a 50 pound box of meat when he twisted his body towards the left and felt a pop in his low back. Diagnoses included lumbar disc displacement and lumbago. Conservative care has included medications, therapy, lumbar epidural steroid injections without benefit, chiropractic treatment, and modified activities/rest. Exam showed lumbar spine with tenderness across the iliac crest into the lumbosacral spine, most pronounced on the right side extending down the right lower extremity; positive seated nerve root test with guarded and restricted lumbar range with intact circulation, coordination and balance; tingling at lateral thigh, anterolateral leg and foot and L5 dermatomal pattern with full strength in the EHL, an L5 innervated muscle. MRI of the lumbar spine of 2/19/14 showed multilevel disc dessication with herniation and stenosis. Plan of care included a comprehensive exercise program, weight loss and possible surgical intervention could not be ruled out. The injured worker was to return to full duty without limitations on a trial basis. Electrodiagnostic studies which must include needle EMG is recommended where a CT or MRI is equivocal and there are ongoing pain complaints that raise questions about whether there may be a neurological compromise that may be identifiable (i.e., leg symptoms consistent with radiculopathy, spinal stenosis, peripheral neuropathy, etc.).

However, the patient already had an MRI of the lumbar spine showing disc extrusion resulting in canal and neural foraminal narrowing for nerve compromise along with clinical neurological deficits consistent with lumbar radiculopathy with previous epidural steroid injections negating any medical necessity for diagnostic EMG. The EMG of the right lower extremity is not medically necessary and appropriate.

NCV of the right lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Complaints Section

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 12-8 309.

Decision rationale: This 21 year old male sustained a work related injury on 4/1/13 from picking up a 50 pound box of meat when he twisted his body towards the left and felt a pop in his low back. Diagnoses included lumbar disc displacement and lumbago. Conservative care has included medications, therapy, lumbar epidural steroid injections without benefit, chiropractic treatment, and modified activities/rest. Exam showed lumbar spine with tenderness across the iliac crest into the lumbosacral spine, most pronounced on the right side extending down the right lower extremity; positive seated nerve root test with guarded and restricted lumbar range with intact circulation, coordination and balance; tingling at lateral thigh, anterolateral leg and foot and L5 dermatomal pattern with full strength in the EHL, an L5 innervated muscle. MRI of the lumbar spine of 2/19/14 showed multilevel disc dessication with herniation and stenosis. Plan of care included a comprehensive exercise program, weight loss and possible surgical intervention could not be ruled out. The injured worker was to return to full duty without limitations on a trial basis. Per Guidelines, NCS is not recommended as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Per Guidelines, NCS is not recommended as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy; hence, NCS without suspicion or findings of entrapment syndrome has not been established to meet guidelines criteria. Electrodiagnostic studies for ongoing pain complaints that raise questions about whether there may be a neurological compromise that may be identifiable (i.e., leg symptoms consistent with radiculopathy, spinal stenosis, peripheral neuropathy, etc.) may be appropriate; however, submitted reports have not demonstrated any correlating symptoms and clinical findings to suggest peripheral neuropathy, or entrapment syndrome, but only with continued chronic lumbar radicular pain. The NCV of the right lower extremity is not medically necessary and appropriate.

EMG of the left lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Complaints Section

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): Table 12-8 309.

Decision rationale: This 21 year old male sustained a work related injury on 4/1/13 from picking up a 50 pound box of meat when he twisted his body towards the left and felt a pop in his low back. Diagnoses included lumbar disc displacement and lumbago. Conservative care has included medications, therapy, lumbar epidural steroid injections without benefit, chiropractic treatment, and modified activities/rest. Exam showed lumbar spine with tenderness across the iliac crest into the lumbosacral spine, most pronounced on the right side extending down the right lower extremity; positive seated nerve root test with guarded and restricted lumbar range with intact circulation, coordination and balance; tingling at lateral thigh, anterolateral leg and foot and L5 dermatomal pattern with full strength in the EHL, an L5 innervated muscle. MRI of the lumbar spine of 2/19/14 showed multilevel disc dessication with herniation and stenosis. Plan of care included a comprehensive exercise program, weight loss and possible surgical intervention could not be ruled out. The injured worker was to return to full duty without limitations on a trial basis. Electrodiagnostic studies which must include needle EMG is recommended where a CT or MRI is equivocal and there are ongoing pain complaints that raise questions about whether there may be a neurological compromise that may be identifiable (i.e., leg symptoms consistent with radiculopathy, spinal stenosis, peripheral neuropathy, etc.). However, the patient already had an MRI of the lumbar spine showing disc extrusion resulting in canal and neural foraminal narrowing for nerve compromise along with clinical neurological deficits consistent with lumbar radiculopathy with previous epidural steroid injections negating any medical necessity for diagnostic EMG. The EMG of the left lower extremity is not medically necessary and appropriate.

NCV of the left lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Complaints Section

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Table 12-8 309.

Decision rationale: This 21 year old male sustained a work related injury on 4/1/13 from picking up a 50 pound box of meat when he twisted his body towards the left and felt a pop in his low back. Diagnoses included lumbar disc displacement and lumbago. Conservative care has included medications, therapy, lumbar epidural steroid injections without benefit, chiropractic treatment, and modified activities/rest. Exam showed lumbar spine with tenderness across the iliac crest into the lumbosacral spine, most pronounced on the right side extending down the right lower extremity; positive seated nerve root test with guarded and restricted lumbar range with intact circulation, coordination and balance; tingling at lateral thigh, anterolateral leg and foot and L5 dermatomal pattern with full strength in the EHL, an L5 innervated muscle. MRI of the lumbar spine of 2/19/14 showed multilevel disc dessication with herniation and stenosis. Plan of care included a comprehensive exercise program, weight loss and possible surgical intervention could not be ruled out. The injured worker was to return to full duty without

limitations on a trial basis. Per Guidelines, NCS is not recommended as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Per Guidelines, NCS is not recommended as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy; hence, NCS without suspicion or findings of entrapment syndrome has not been established to meet guidelines criteria. Electrodiagnostic studies for ongoing pain complaints that raise questions about whether there may be a neurological compromise that may be identifiable (i.e., leg symptoms consistent with radiculopathy, spinal stenosis, peripheral neuropathy, etc.) may be appropriate; however, submitted reports have not demonstrated any correlating symptoms and clinical findings to suggest peripheral neuropathy, or entrapment syndrome, but only with continued chronic lumbar radicular pain. The NCV of the left lower extremity is not medically necessary and appropriate.